Updated 11/18/2021

Administrative Transfer Request Form SIA to State Hospital

SECTION I (General Information):

Date:

Patient name: Age:

DOB: Gender: SSN:

Current facility (SIA)

County (of legal charges):

Date entered current facility:

Case number:

Charges or convictions:

Attach MH Screen & Court Documents

LEGAL STATUS:

☐ 59-2949 Voluntary
☐ 59-2954 Emergency Treatment
☐ 59-2958 Exparte Order
☐ 59-2959 Temporary Custody
☐ 59-2964 Continuance & Referral
☐ 59-2966 Treatment Order
☐ 59-2967 Outpatient Treatment Order

Has probable Cause Hearing occurred?

☐ Yes ☐ No

If yes, what County?

Next hearing date:

Is person out on bond: ☐ Yes ☐ No

☐ Aggression (explain and provide date of last incident):
☐ Use of restraints (explain):

SECTION II (Medical):

Name and title of person providing medical information:

List of medications:

Is this person compliant with medications: ☐ Yes ☐ No

Comments:

TB skin test (date/results):

Is this person considered to be at imminent risk of danger to others: ☐ Yes ☐ No

Comments:

Is this person considered to be at imminent risk of danger to self (i.e. Self care failure, suicidal or self harm gestures): ☐ Yes ☐ No

Comments:

Is this person considered vulnerable (i.e. impaired cognitive and/or developmental functioning (I/DD, neurocognitive disorder)? ☐ Yes ☐ No

Comments:

Does this person have physical vulnerabilities or impairments, history of victimization, vulnerable medical conditions)? ☐ Yes ☐ No

Comments:

COVID-19 Questions:

Does the proposed patient have any COVID-19 symptoms? ☐ Yes ☐ No

If yes, please explain:

Has the proposed patient had a COVID test? ☐ Yes ☐ No

If yes, date of COVID test: ☐ Positive ☐ Negative

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Have there been positive cases (current or previous) at your facility? ☐ Yes ☐ No

If yes, was the proposed patient exposed? ☐ Yes ☐ No If yes, please explain:

Is the proposed patient under quarantine? ☐ Yes ☐ No If yes, please explain:

Please provide any other information related to COVID-19 and the proposed patient:

DOES THIS PATIENT HAVE ANY OF THE FOLLOWING OR BEEN EXPOSED TO THE FOLLOWING:
(*IF BOX IS CHECKED EXPLANATION IS REQUIRED)*

- ☐ Medical Concerns, Diagnoses, and/or Devices (including medical diagnoses, need for wheelchairs, walkers, eye glasses, hearing aids, etc.) (explain):
- ☐ Food Allergies or other dietary needs (explain):
- ☐ Drug Allergies (explain):
- ☐ Other Allergies (explain):
- ☐ Pregnant (due date):
- ☐ Lice or Scabies (explain):
- ☐ Influenza (explain):
- ☐ Respiratory Illness (Explain):
- ☐ Disease (explain):
- ☐ History of Multi-Drug Resistant Organism (e.g. MRSA) (explain):
- ☐ Wounds or lacerations (explain):
- ☐ Guardian or DPOA (Provide contact information and Letter of Guardianship or DPOA):
- ☐ Intellectual or Developmental Disability or cognitive impairment (explain):
- ☐ Suicidal or self-harming behaviors (explain and provide date of last incident):
- ☐ Sexual behaviors of concern (explain):
- ☐ Active psychosis or delusions (explain):
- ☐ Substance Abuse (explain):
- ☐ Cultural needs: (explain):
- ☐ Other (explain):

Name, title and contact information for current medical provider:

ANY COMMUNICATION BARRIERS (deaf, mute, primary language other than English, etc.) (explain):

Reason for Referral/Transfer:

Printed Name	Phone Number	Email

Signature	Date	Time

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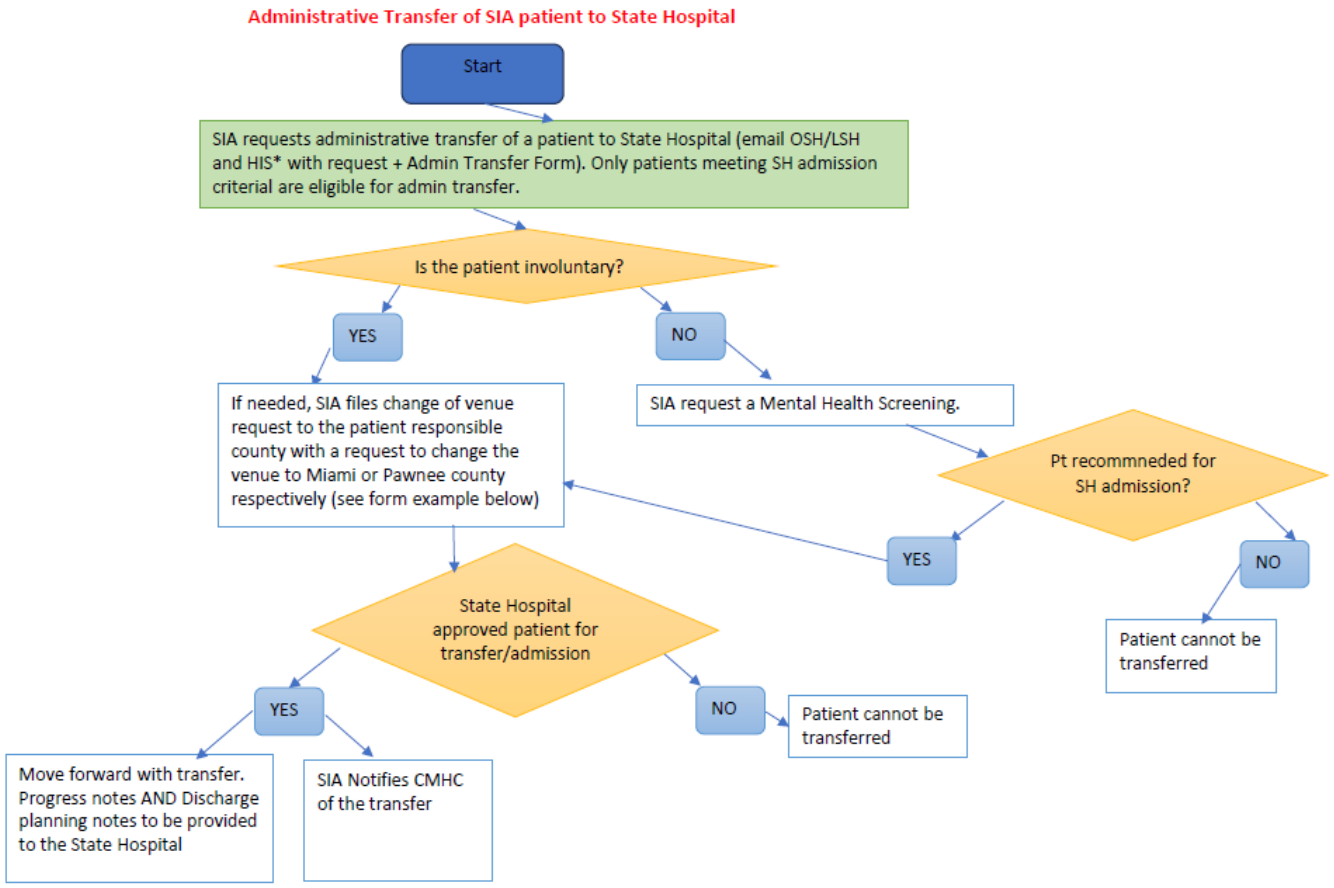

* LSH Contact for Transfers: nicole.tice@ks.gov
OSH Contact for transfers: ashley.byram@ks.gov; osh.triage@ ks.gov
HIS - Health Source Integrated Solutions contact: sia@healthsrc.org llibel@healthsrc.org

WRITTEN NOTICE TO THE COURT OF CHANGE OF STATUS

Date:

To: District Court of _____County Kansas

Court No.:
You are hereby notified that _____ admitted on DATE to NAME Hospital has been:
☐ Accepted on voluntary status
☐ Discharged while on hospital visit to Click or tap here to enter text.
☐ Placed on hospital visit to Click or tap here to enter text.
☐ Returned from hospital visit from Click or tap here to enter text.
☐ Discharged while on AWOL status
☐ Placed on AWOL status
☐ Returned from AWOL status
☐ Direct permanent transferred to Click or tap here to enter text.
☐ Temporary transferred to: Larned State Hospital on October 23, 2021.
☐ Deceased on Click or tap here to enter text.
☐ Placed in the care of CMHC per the directive of County's pending their outpatient treatment order.

By: NAME OF THE PERSON SUBMITTING Cc: Patient Medical Record (#_____)

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